Editorials

Medicine in Extraordinary Times

WE LIVE in a period of unprecedented transition both in medicine and in society. There is awesome political upheaval or potential upheaval in many parts of the world. And overshadowing everything everywhere is the destructive threat of nuclear power, were it ever to fall into irresponsible hands. And there are many other risks to human health that also result from progress and achievement in modern science and technology. Even biomedical science in its own way seems to be creating problems in health and health care rather than giving the answers that many hoped and expected it would. These are surely extraordinary times. There are risks, but there are also opportunities for the imaginative and innovative who would take risks.

In many ways medicine and health care are an underlying cause of much that now requires transition and social change, at least in America. For example, more infants and children are living to grow up, and after they grow up, they are living longer. The costs of child care and care of the aged are rising, and the resources for this care are inadequate. Industrial pollutants of land, water, and air are beginning to affect health in innumerable ways and are requiring costly social change to prevent the ill effects that physicians are seeing in their offices. Human behaviors, both normal and in aberration, are having profound effects on the larger society and on health and the costs of health care. New interactions and new interdependencies are developing among physicians, the health care enterprise, and the larger society. All of this is transforming patient care, the health care system, and societal expectations for healthy life-styles and personal well being. This is surely a time of opportunity for physicians. It is a time of opportunity for reaffirmation and renewal in the medical profession.

In circumstances such as these, there is an expectation of change and a desire to move on to better things, and this desire is clearly evident in health care. One senses a widespread determination somehow to do better with access, quality, efficiency, outcomes, and costs. But no one seems to know quite what to do. There is no real precedent or model to follow. Our nation and our health care needs are too diverse to be well served by any existing model. Our expectations for health and health care may often be unrealistic, but they are real. We find ourselves groping for truly American ways of meeting these very real needs and expectations. How it will all turn out is not yet at all clear, but there is a smell of change in the air, and with change come opportunities for the imaginative and innovative.

Quite appropriately, this is also a time of transition, renewal, opportunity, and, no doubt, innovation, for *The Western Journal of Medicine*. Beginning with the next issue (Volume 153), it will be under the direction of a new editor. Linda Hawes Clever, MD, assumes the editorship of this, the official scientific journal of nine western medical associations. Looking ahead, one may assume that bioscience and biotechnology will contine to progress, that socioeconomic imperatives will continue to have their effect on health care, that ethical issues resulting from medical progress will bring the larger society into closer touch with medical practice and the realities of patient care. One may expect that somehow, because of the unquenchable dedication of individual physicians, medicine will remain a humanitarian calling and not become either a business, focused only on the "bottom line," or simply a trade composed of technicians who market their specialized technical skills to the providers and consumers of health care, however these might come to be defined. But there will be change and, no doubt, progress.

The new editor will find a journal ready to report to its readers on the bioscience and biotechnical advances that will occur; on the fascinating developments that are sure to come about as the art of medicine in patient care becomes more specifically defined in relation to the evolving social, economic, and political health care environment; and on the future interactions of medicine with the larger society, which will become increasingly important as both grapple with human health and even human survival in these extraordinary times.

This retiring editor wishes Dr Clever every success and would remind her that this distinguished journal will celebrate its 100th anniversary in the year 2002, just a few years hence!

MSMW

Kidney Transplant Revisited (1990)

IN THE MORE than 35 years of clinical renal transplantation, significant improvements have been made in this undertaking. Two-year patient and graft survivals of 95% and 80% to 90%, respectively, are generally being realized, and there is an acceptance that renal transplantation is preferable to chronic dialysis for cost as well as quality-of-life considerations. Suranyi and Hall detail the current state of the art of renal transplantation in their article that encompasses many of these advances to the present stage.[1] In describing the present clinical field of transplantation, moreover, the authors point out current and future problems in this endeavor. These problems include pragmatic, social, as well as more theoretic and basic scientific issues.

The first pragmatic problem is one of donor supply. Although renal tranplantation offers the possibility of living donor utilization (in contrast to other solid organs), the long-term risk (that is, risk to donors for more than 20 years after a donor nephrectomy) to such donors has until now not been clearly described. In addition, many living donors turn out not to be physiologically acceptable for donation.[2] Living unrelated donors offer another donor "pool" possibility, but outcomes in the recipients of these sorts of transplants may only approximate the current results of cadaver donor transplantation. It appears that the currently used donor "pool" for cadaver kidneys has a threefold to fourfold shortfall for prospective renal transplant recipients.[3] One useful, practical response has been the coordination of population donor education programs through the United Network of Organ Sharing (UNOS), which encourages cadaver multiorgan donation. With the increasingly improved results with liver, heart, heart-lung, and pancreas transplants—in addition to the historically good, cadaver kidney transplant results—